Glossary and List of Acronyms

Access: The degree to which services are readily obtainable – determined by the extent to which needed services are available and information about these services is provided, the responsiveness of the system to individual cultural and linguistic needs, and the convenience and timeliness with which services are obtained.

Assessment : The process of documenting, usually in measurable terms, knowledge, skills, attitudes and beliefs. Cultural competence assessments often include a set of specific indicators (measures) that are used as tools to examine, demonstrate and document cultural competence in organizations.

Bilingual staff: Individuals who have some degree of proficiency in more than one language. Bilingual staff includes those who serve in a dual role, providing interpreter services in addition to their primary position.

Community-based participatory research (CBPR): In CBPR, community-based organizations help researchers recruit subjects and play a direct role in designing and conducting research studies. Community members then share the research findings directly with the community.

Community health workers: Health professionals that offer informal counseling and social support, health education, advocacy, referral and follow-up services to clients. Research studies show that community health workers improve health outcomes among racially, ethnically and linguistically diverse populations. By serving as the bridge between clients and health services, they improve access to primary health care, reduce costs of care, improve quality of care and reduce health disparities.

Competence: Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by people and their communities.

Cultural broker: An individual who bridges, links, or mediates between groups or persons of differing cultural backgrounds for the purpose of reducing conflicts, producing change, or advocating on behalf of a cultural group or person. Cultural brokers can also be medical professionals who draw upon cultural and health science knowledge and skills to negotiate with the patient and health system toward an effective outcome.

Cultural competence:

- The capacity to value diversity, conduct self-assessment, manage the dynamics of difference, institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities served
- Incorporating the requirements above in all aspects of policy development, administration, and practice/service delivery and involving consumers systematically

Culturally and linguistically appropriate services: Health services that are respectful of and responsive to cultural and language needs.

Culture: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Disparities: Differences in health care that are attributable to racial and/or ethnic factors and that are not attributable to other known factors.

Effective communication: A critical component to the client's understanding of the informed consent process, participation in his or her care, understanding of all information provided to him or her, and ability to fulfill the responsibilities related to his or her care. In order for communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient.

Ethnicity: A person's background, heritage, culture, ancestry, or sometimes the country where persons or their families were born.

Health equity: 1) Distribution of disease, disability and death in such a way as to not create a disproportionate burden on one population. 2) The absence of persistent health differences over time between racial and ethnic groups.

Health literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate heatlh decisions.

Interpretation: The oral restating in one language of what has been said in another language.

Language services: Mechanisms used to facilitate communication with individuals who do not speak English and those who are deaf or hard-of-hearing. These services can include in-person interpretation using a professional interpreter, bilingual staff, or remote interpreting systems such as telephone or video medical interpreting. Language services also refer to processes in place to provide translation of written materials or signage.

Linguistic competence: The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with visual and hearing impairments.

Limited English Proficient (LEP): An LEP individual is a person who is unable to speak, read, write or understand the English language at a level that permits him or her to interact effectively with health and social service agencies and providers.

Mutual Assistance Association (MAA): Self-help organizations that assist newcomer communities in the process of adjusting to a new country. Through education, social and other support services, MAAs are closely linked with communities of diverse cultures.

National Standards on Culturally and Linguistically Appropriate Services (CLAS standards): The set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Patient-centered care: Health care that establishes a working partnership with patients and their families to ensure decisions are made that respect and honor patients' wants, needs, and preferences and to ensure that patients have the education and support they need to act as a central resource in their own health and/or the health of their family.

Plain language: Clear, straightforward expression, using only as many words as necessary. It is language that avoids obscurity, inflated vocabulary and convoluted sentence construction. It is not baby talk, nor is it a simplified version of the language. Writers of plain language let their audience concentrate on the message instead of being distracted by complicated language.

Planning : The organizational process of creating and maintaining a plan and the process of thinking about the activities required to create a desired goal on some scale.

Professional health care interpreter: An individual who has the appropriate training and experience to interpret with consistency and accuracy, and who adheres to a code of professional ethics.

Race: Defined as the groups that individuals identify with as having similar physical characteristics or similar social and geographic origins.

Racial bias: A preformed negative opinion or attitude toward a group of persons who have common physical, cultural or linguistic characteristics.

Telephone interpreting: Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through speakerphones or headsets. In health care settings, the principal parties (e.g., doctor and patient) are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone.

Threshold population: A threshold population is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program and Haitian-Creole would be considered a **threshold language.** Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

Translation: Written conversion of written materials from one language to another.

Video medical interpreting: Interpreting that is carried out remotely using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he or she is interpreting via a television monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used so that the other parties can interact with the interpreter as though face-to-face.

Vital documents: For the purposes of ensuring language access, vital documents are written documents that are "vital" to programs or limited English proficient populations. Examples include signs, directions and notices about the availability of interpreter services, legal documents (consent forms, client rights and responsibilities, privacy notices, complaint forms, grievance policies) and client intake forms.

Voluntary Organizations (VOLAGs): Agencies that, through their local affiliates, help resettle newcomer communities.

Portions adapted from: Wilson-Stronks, A. et al. 2008. One Size Does Not Fit All. Meeting the Health Care Needs of Diverse Populations. Oakbrook Terrace, IL: The Joint Commission.

Acronyms Used in this Manual

AHEC	Area Health Education Center
AMP	Affirmative Market Program
CPBR	Community-Based Participatory Research
CHC	Caring Health Center
CHNA	Community Health Network Area
DOJ	U.S. Department of Justice
GNBCHC	Greater New Bedford Community Health Center
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHS	U.S. Department of Health and Human Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	(Persons with) Limited English Proficiency
MassCHIP	Massachusetts Community Health Information Profile
MAA	Mutual Assistance Associations
MCAD	Massachusetts Commission Against Discrimination
MDPH	Massachusetts Department of Public Health
MOD	Massachusetts Office on Disability
MWBE	Minority and Women-owned Business Enterprises
NCQA	National Committee for Quality Assurance
NBWIC	New Bedford Women, Infants and Children
OCR	U.S. Department of Health and Human Services' Office for Civil Rights
ODEO	Massachusetts Office of Disability and Equal Opportunity
OHE	Office of Health Equity (for purposes of this manual, the OHE is the Office of Health Equity at the Massachusetts Department of Public Health)
OSD	Operational Services Division
PHSC	Office of Public Health Strategies and Communications at the Massachusetts Department of Public Health
SOMWBA	State Office of Minority and Women Businesses Assistance
WIC	Women Infants and Children
VOLAG	National Voluntary Agencies

APPENDIX A:

Cultural and Linguistic Competence Guidelines

Guidelines for Cultural and Linguistic Competence

The objective for establishing standards of care for cultural and linguistic competence is to ensure that clients receive services that are culturally and linguistically appropriate.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that enables effective delivery of services. **Linguistic competence** is the ability to communicate effectively with people, including those whose preferred language is not the same as the provider's, those who are illiterate or have low literacy skills, and/or those with disabilities. It is important to remember that cultural and linguistic competence is a goal toward which all providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and linguistically appropriate services to all individuals. **Culturally and linguistically appropriate services** are services that:

- respect, relate to, and respond to a client's culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- consider each client as an individual, and do not make assumptions based on perceived or actual membership in any group or class.

As part of the ongoing process of building cultural and linguistic competence, providers should strive to develop:

- comfort with and appreciation of cultural and linguistic difference;
- interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
- the comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
- a commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

Ongoing trainings that help build cultural and linguistic competence may include traditional cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve.

Guidelines for Cultural and Linguistic Competence

Standard		Measure	
1.1	Programs shall recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.	1.1	Programs will have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of clients.
1.2	All staff shall receive ongoing training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.	1.2	All staff members attend appropriate training at least one (1) time per year. Maintain copies of training verification in personnel file.
1.3	Programs shall understand the cultural and linguistics needs, resources, and assets of their service area and target population(s).	1.3	Programs will collect and use accurate demographic, epidemiological, and service utilization data in service planning for target population(s). Verified through grantee site visit. Data maintained in a place that is easily accessible for review.
1.4	Programs' physical environment and facilities are welcoming and comfortable for the populations served.	1.4	Grantee site visit.
1.5	All programs must ensure access to services for clients with limited English skills.	1.5	Programs shall ensure access to services in one or more of the following ways (listed in order of preference): ■ Bilingual staff who can communicate directly with clients in preferred language; ■ Face-to-face interpretation[1] provided by qualified staff or contract or volunteer interpreters; ■ Telephone interpreter services (for emergency needs or for infrequently encountered languages); ■ Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/ bicultural interpreter.

[1] **Interpretation** refers to verbal communication that translates speech from a speaker to a receiver in a language that the receiver can understand. **Translation** refers to the conversion of written material from one language to another.

Guidelines for Cultural and Linguistic Competence			
Standard		**Measure**	
1.6	Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality and medical terminology issues. If a client chooses to have a family member or friend as his or her interpreter, the provider must obtain a written and signed consent in the client's language. Family member or friend must be over the age of 18.	1.6	Family/friend interpretation consent form signed by client and maintained in client record.
1.7	Interpreters and bilingual staff, volunteers, and contracted providers must demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting and knowledge in both languages of the terms relevant to the services to be provided	1.7	Résumé and documentation of training on file. For interpreters, copy of certification on file at agency.
1.8	Clients shall be informed of their right to obtain no-cost interpreter services in their preferred language.	1.8	Rights and responsibilities policy contains notice of the right to obtain no-cost interpreter services (see Standard 1.0).
1.9	Clients shall have access to linguistically appropriate signage and educational materials.	1.9	Programs must provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc.) in the threshold language[2] of all threshold populations.[2] Prgrams that do not have threshold populations[2] must have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.
1.10	Programs shall conduct ongoing assessments of the program and staff's cultural and linguistic competence.	1.10	Programs will integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

[2] A **threshold population** is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program and Haitian-Creole would be considered a **threshold language.** Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

Source: Standards of Care for HIV/AIDS Services. 2004. Released by the Massachusetts Department of Public Health HIV/AIDS Bureau and the Boston Public Health Commission's AIDS Services and the Boston AIDS Consortium.

APPENDIX B:

Overview of Laws

Appendix B: Overview of Laws Supporting Culturally and Linguistically Appropriate Services

Title VI and Derived Guidelines:

- U.S. Department of Justice (DOJ) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) **http://www.usdoj.gov/crt/cor/coord/titlevi.htm**
- U.S. Department of Health and Human Services (HHS) Office of Civil Rights Title VI regulations (45 C.F.R. Section 80.3 (b) (2) and Title VI LEP Guidance (68 Fed. Reg. 50121) **http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep**
- Presidential Executive Order 13166: Improving access to services for persons with limited English proficiency (65 Fed. Reg. 50121) **http://www.lep.gov/13166/eo13166.html**

Overview

Title VI and related guidance and guidelines require agencies receiving federal financial assistance to:

- Prohibit discrimination on the basis of race, color, and national origin in programs and activities
- Examine the services they provide, identify any need for services for Limited English Proficiency (LEP) populations, and develop and implement a system to provide identified services
- Offer recommendations on identifying LEP populations, interpreting and translation, training, and elements of effective language plans

To Whom They Apply

- Any organization receiving federal financial assistance, directly or indirectly
- Grantees, subgrantees, contractors
- Almost all health care providers (Medicaid, SCHIP, and block grants to health and welfare agencies all receive federal financial assistance)

Other Federal Laws Governing Culturally and Linguistically Appropriate Services

- Hill-Burton Act "Hospital Survey and Construction Act" (42 U.S.C. 291 et seq.)
- Medicaid, State Children's Health Insurance Program (SCHIP) and Medicare statutes and regulations

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Massachusetts' Commitment to Reducing Disparities

Executive Order no. 478: Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action (2007)

Overview

Issued as a state priority in 2007, this order details measures to ensure non-discrimination and diversity in state agencies, state-funded programs and service providers.

To Whom it Applies

State agencies, grantees, state-licensed programs, state-funded programs, contracted service providers and subcontractors

Requirements

- Adapt programs and services to prevent discrimination and meet needs of diverse groups (section 2)
  - Increase workforce diversity (section 3):
    - Develop affirmative action, diversity plans
    - Recruit and promote employees from under-represented groups
    - Adopt equal opportunity employment policies
  - Contractors must commit to non-discrimination practices (section 5):
    - Comply with fair labor and employment laws
    - Commit to purchasing services from minority, women-owned and small businesses
  - Offer mandatory diversity training (section 10)
    - Establish a complaint resolution process for non-compliance with anti-discrimination laws

Massachusetts' Commitment to Immigrants and Refugees

Executive Order 503: Integrating Immigrants and Refugees into the Commonwealth (2008)

Overview

Issued as a state priority on July 30, 2008, this order introduces the "New Americans Agenda" uniting resources from various state and nonprofit agencies to ease the transition of immigrants and refugees.

To Whom it Applies

State departments, offices, divisions and agencies

Requirements

- Follow recommendations from the Massachusetts Office of Refugees and Immigrants (MORI) to develop New Americans plans that incorporate:
  - Effective training and resources;
  - Culturally and linguistically competent and appropriate services; and
  - Administrative practices that address the needs of immigrants and refugees (Sec. 5).
- Plans must be in accordance with recommendations from MORI.
- Plans must be submitted within a year of receipt of MORI recommendations.

State and Federal Policies that Emphasize the Collection of Race, Ethnicity and Language (REL) Data

- Massachusetts Executive Order No. 478: Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action
- Office of Management and Budget (OMB) revised standards (1997) **http://www.whitehouse.gov/omb/fedreg/ombdir15.html**
- Health Insurance Portability and Accountability Act of 1996
- Initiative to Eliminate Racial and Ethnic Disparities in Health (1998)
- Consumer Bill of Rights and Responsibilities (1997)
- Benefits Improvement and Protection Act (2000)
- Report of U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity* (1999)
- Executive Order No. 13166 "Improving Access to Services for Persons with Limited English Proficiency" and Executive Order No. 13125 "Improving the Quality of Life of Asian Americans and Pacific Islanders" (2000)
- Minority and Health Disparities Research and Education Act of 2000
- Department of Health and Human Services Title VI Regulations (1964)
- Department of Health and Human Services Inclusion Policy (1997)
- Title VII of the Civil Rights Act of 1964
- Healthy People 2010 (2000)
- Culturally and Linguistically Appropriate Services Standards (2001)
- HHS Data Council Activities (ongoing)
- National Committee on Vital Health Statistics (ongoing)
- The Joint Commission standard to collect client's primary language information (2006) **http://www.jointcommission.org/Standards/Requirements**
- M.G.L.A. 272, Section 98, Public Accommodations Law

Laws Governing Culturally Competent Grievance Processes

Massachusetts Executive Order No. 478, section 11

Section 11 of Executive Order No. 478[i] grants power to the Massachusetts Office of Diversity and Equal Opportunity (ODEO) and the Massachusetts Office on Disability (MOD) to develop guidelines establishing a complaint resolution process for individuals who allege discrimination.

In cases where this process does not resolve the complaint, ODEO and MOD can submit complaints to the Massachusetts Commission Against Discrimination (MCAD). The MCAD can initiate investigations and, where necessary, file complaints against agencies or persons in violation of anti-discrimination laws.

According to Massachusetts Health Insurance Consumer Protection Law 105 CMR 128.000, clients must be offered:

- A clear, concise and complete written description of the internal grievance process;
- Toll-free telephone numbers for assistance; and
- Notification regarding availability of these resources.

Laws and Policies Regarding the Provision of Language Access Services for Limited English Proficient (LEP) Populations

Hill-Burton Community Service notice, U.S. Department of Health and Human Services, provisions of 42 C.F.R. 124.604(a), requires that clients be notified of the availability of interpreter services at all points of contact.

U.S. Health and Human Services Office of Civil Rights (OCR) Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Individuals

http://www.hhs.gov/ocr/civilrights/specialtopics/lep

OCR "Safe Harbor Laws"

The "Safe Harbor Laws" establish that organizations can offer sufficient proof that they are making an effort to meet the needs of LEP groups by providing written translations for at least:

- Ten percent of the eligible population or 3,000 clients, whichever is less, for all documents
- Five percent of the eligible population or 1,000 clients for the most vital documents[ii]

Massachusetts Department of Public Health Best Practice Recommendations for Hospital-Based Interpreter Services

Massachusetts Department of Public Health (MDPH) best practice recommendations for hospital-based interpreter services suggest that written translations should be provided for LEP populations that make up 15% of a program's clients.[iii]

[i] See Massachusetts Executive Order No. 478, Section 11.

[ii] U.S. Department of Health and Human Services, Office for Civil Rights. *Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Individuals.* Viewed July 18, 2008 (http://www.hhs.gov/ocr/civilrights/specialtopics/lep.

[iii] Torres, Brunilda. 2001. *Best Practice Recommendations for Hospital-Based Interpreter Services.* Massachusetts Department of Public Health. Office of Health Equity.

APPENDIX C:

Accessible Print Materials

Accessible Print Materials

Formatting Guidelines to Accommodate All Audiences

Developed by the Massachusetts Department of Public Health,
Office on Health and Disability, 2007

HEALTH MESSAGES should be designed for diverse audiences, including people with disabilities. The Massachusetts Department of Public Health (MDPH) in adherence with the Americans with Disabilities Act (ADA) requires that members of the general public with disabilities have communication access that is equally effective as that provided to people without disabilities.[1]

The MDPH Office on Health and Disability has developed guidelines for accessible printed health communications. These guidelines contain MDPH policies, recommended standards, and suggested websites for accessible design and print information. Additional resources for alternative communication services are also included.

[1] Department of Justice Nondiscrimination on the Basis of State and Local Government Services Regulation, 28 C.F.R. Part 35, § 35.160 (2005). Available at www.ada.gov/reg2.html.

Content of Health Promotion Materials

1

Materials should reflect your target audience. Materials should be culturally and linguistically appropriate.

The target population should be inclusive of individuals with disabilities.

Make sure that:

- Materials identify disability as a risk factor for health conditions where appropriate.
- During all phases of the material development process, including initial discussions, concept testing, and focus groups, the target audience sample should include people with disabilities, unless the target audience is so specific it can be documented that people with disabilities would never be a member of that audience.

Contrast / Paper Finish

2

Use dark lettering over a light colored background on non-glossy paper.

Make sure that:

- Light yellow or off-white non-glossy/matte paper is used for print. It can be difficult to manipulate and read from glossy paper.

- Dark text is used on a light background and light text is used on a dark background. Print material is most readable in black or see examples of effective print legibility at **http://lighthouse.org/print_leg.htm**

- Color text is used primarily for headlines and titles where a larger font size can be applied. A high contrast (70 percent) between text and background is best. See examples of effective color contrast at **http://www.lighthouse.org/accessibility/effective-color-contrast/**

Text / Fonts

Use simple fonts without excessive special formatting.

Make sure that:

- Font selection is simple. Do not use compressed (**Print Example**), condensed (**Print Example**), complicated (Print Example), decorative (Print Example), or cursive (*Print Example*) fonts.

- Materials display standard serif or sans-serif fonts, with familiar, easily recognizable characters. Serif refers to fine lines that project from the letter type. Note that some font styles are naturally smaller than others. The examples below show different font styles in 14-point size.

  Serif: Times New Roman, Bookman, Courier New

  San-serif: Arial, Century Gothic, Verdana

- Font size is no smaller than 12 point. When possible use 14 point font. Large print materials use between 16 and 18 point. See font size examples below:

  12 point, 14 point, 16 point, 18 point

- Formatting codes such as *italics*, **bold**, and *oblique,* are used sparingly. Avoid writing in this format for entire sections and documents.

- Underlining does not connect with the letters being underscored.

- Text is not written completely in all upper case lettering.

Design Layout

Materials should be designed with clear margins and spacing for ease in finding the beginning of the next line.

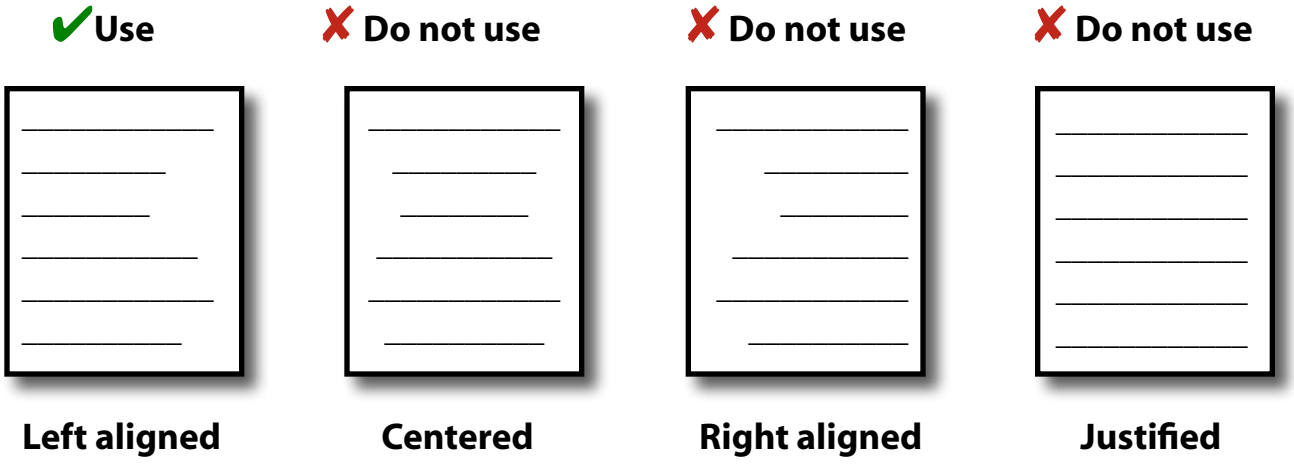
Make sure that:

- The gutter margins (the adjoining margins in two facing pages) are a minimum of 7/8 of an inch and the outside margins are at least half an inch. The space between any columns is at least half an inch.

- Spacing between lines of text is at least 25 percent of font size. MS Word documents automatically type in single space (0 percent).
  - To edit line spacing, select the Format tab in the tool bar and then the Paragraph tab.
  - In the drop-down box for line spacing you can select options such as 1.5 line spacing (50 percent of font size) or Double-Spacing (100 percent of font size).

- Select "Multiple" in the line-spacing drop down box. In the next box labeled "At", type in 1.25 percent (25 percent) to meet minimum recommended standards.

- The main text is left aligned. Right margins are ragged, not justified, because centered and right aligned text is difficult for some people to track.



- Each line of text is no longer than six inches (50-60 characters per line). Avoid excessively short text lines and hyphenations at the end of lines.

- Hyphenation can be turned off in MS Word by selecting the Format tab, then under Paragraph, Line and Page Breaks, checking the "Don't Hyphenate" box.

- Bound documents are flexible, preferably allowing the publication to lie flat. Spiral binding is recommended for lengthy documents.

Use of Images

5

Health promotion materials should use images representing the target population including people with disabilities. Images should have sufficient resolution and significant color contrast for easy viewing.

Make sure that:

- Images have a wide range of **color contrast** or **gray-scale** variation.

- Labels are used for each image with at least 12 point font.
  - See examples below from Active Living By Design (1,2) http://www.activelivingbydesign.org/index.php?id=335 and (3) Northeast Passage http://www.nepassage.org

1. Couple Walking

2. Friends relaxing

3. Adaptive Sled Hockey

- Line drawings or floor plans are clear and bold, with limited detail and a minimum 12-point font.

- Graphics such as watermarks are not used over or behind any other images, photographs, graphics, or text.

Policy Statement Regarding Public Announcements and Accommodations

6

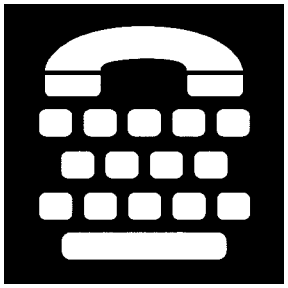
The following statement and symbols are required on all Massachusetts Department of Public Health publicity.

- To address how accommodations for a person with a disability or someone who is deaf or hard of hearing may be arranged, all materials advertising public events sponsored and/or coordinated by the Massachusetts Department of Public Health (MDPH) should include the following statement:

  - "If you are deaf or hard of hearing, or are a person with a disability who requires accommodation, please contact [Name of organization or individual responsible for making arrangements] at [Telephone Number], [Fax Number], [Email Address] or [TTY Number] by [Date]."

- Along with the accessibility statement, include these five access symbols which may be found at the Graphics Artst Guild website at: **http://www.gag.org/resources/das/php**

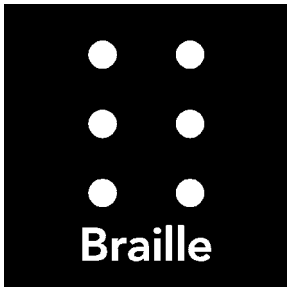
1



2

3

4

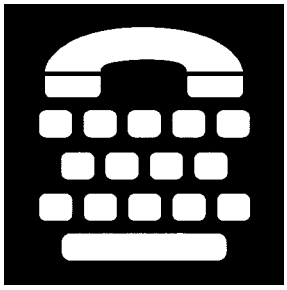


5

- The access symbols are described next according to the Graphics Artist Guild.

1. Symbol for accessibility.

The wheelchair symbol should only be used to indicate access for individuals with limited mobility including wheelchair users. For example, the symbol is used to indicate an accessible entrance or bathroom, or that a phone is lowered for wheelchair users. Remember that a ramped entrance is not completely accessible if there are no curb cuts, and an elevator is not accessible if it can only be reached via steps.



2. Symbol for Telephone Typewriter.

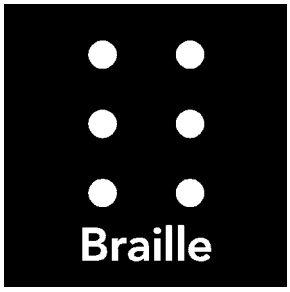
This device is also known as a text telephone (TT), or telecommunications device for the deaf (TDD). A telephone typewriter (TTY) symbol indicates a device used with the telephone for communication with and between deaf, hard of hearing, speech impaired and/or hearing persons.

3. Symbol for Sign Language Interpretation.

This symbol indicates that Sign Language Interpretation is provided for a lecture, tour, film, performance, conference or other program.

4. Symbol for Volume Control Telephone.

This symbol indicates the location of telephones that have handsets with amplified sound and/or adjustable volume controls.



5. Symbol for Braille.

This symbol indicates that printed material is available in Braille, including exhibition labeling, publications and signage.

Interpreter and Translation Services

Programs may contact the following offices for assistance with accommodations.

■ **To request interpreter services for individuals who are deaf or hard of hearing contact: MA Commission for the Deaf and Hard of Hearing (MCDHH).**
Interpreter/ CART (Communication Access Real Time Translation) Referral Service.

MCDHH is a state agency under the Executive Office of Health and Human Services.
Address: 150 Mt. Vernon Street, Fifth Floor, Boston, MA 02125
Phone: 617-740-1600 or 800-882-1155
TTY: 617-740-1700 or 800-530-7570
Fax: 617-740-1880

Visit **http://www.mass.gov/mcdhh** for more information on how to request any of the following:

- sign language interpreter;
- an emergency interpreter (TTY/Voice: 800-249-9949);
- information for interpreters; or
- a CART provider.

■ **To request interpretation for spoken language and translation of written material into other languages contact:**

The Office of Multicultural Health (OMH) at MDPH.
Address: 250 Washington Street, Fifth Floor, Boston, MA 02108
Phone: 617-624-6063
TTY: 617-624-5992

OMH must be contacted prior to the final approval of written documents in English that will be translated into other languages. Translation guidelines and related forms may be found at:
http://www.mass.gov/dph/omh/omh.htm

Braille Transcription Services

Programs may contact the following offices for assistance with accommodations.

■ **To request transcription of written material into Braille contact:**
Fergusson Industries for the Blind, a division of the MA Commission for the Blind (MCB).

You may contact **Fergusson Industries for the Blind** directly at:
Address: 11 Highland Avenue, Malden, MA 02148
Phone: 781-324-0800
TTY: 781-324-1800
Fax: 781-324-3111
Email: IndustBraille@MassMail.State.Ma.Us

MA Commission for the Blind (MCB) is a state agency under the Executive Office of Health and Human Services. For more information on MCB services or additional inquiries related to Braille transcription services, contact:

The MCB Office of Information Services
Address: 48 Boylston Street, Boston, MA 02116
Phone 617-727-5550
TTY: 800-392-6556
Fax: 617-626-7685
or visit the MCB website at **http://www.mass.gov/mcb**

Example of Braille Transcription Price Guide from Fergusson

Setup Fee (per file)	$5.00
Small Binding (less than 1" spine)	$2.00
Editing (other than minor fix-up)	$15.00/hr
Double Sided (8 1/2" X 11") Page	$1.00
Large Binding (1" spine or larger)	$4.00

Material to be transcribed should be submitted in Word, Word Perfect, or ASCII plain text file (.txt).

For more information and other publications, including:

- Planning Accessible Meetings and Events
- Plan for Promoting the Health of People with Disabilities

Please contact:
Massachusetts Department of Public Health
Office on Health and Disability
250 Washington Street, 4thFloor, Boston, MA 02108
Phone: 617-624-5070
TTY: 617-624-5992

To find our website, go to **http://www.mass.gov/**
Type "Health and Disability" into the search box and click on the search button.
On the Results Page, click on: **"Healthy Aging, Health and Disability Activities".**

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